RESIDENT ASSESSMENT

28-39-151. Resident assessment. Each nursing facility shall conduct at the time of admission, and periodically thereafter, a comprehensive assessment of a resident's needs on an instrument approved by the secretary of health and environment.

(a) The comprehensive assessment shall include at least the following information:

(1) Current medical condition and prior medical history;

(2) measurement of the resident's current clinical status;

(3) physical and mental functional status;

(4) sensory and physical impairments;

(5) nutritional status and impairments;

(6) special treatments and procedures;

(7) mental and psychosocial status;

(8) discharge potential;

(9) dental condition;

(10) activities potential;

(11) rehabilitation potential;

(12) cognitive status; and

(13) drug therapy.

(b) A comprehensive assessment shall be completed:

(1) not later than 14 days after admission;

(2) not later than 14 days after a significant change in the resident's physical, mental, or

psychosocial condition; and

(3) at least once every 12 months.

(c) The nursing facility staff shall examine each resident at least once every three months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(d) Changes in a resident's condition which are self-limiting and which will not affect the functional capacity of the resident over the long term do not in themselves require a reassessment of the resident.

(e) The nursing facility shall use the results of the comprehensive assessment to develop, review, and revise the resident's comprehensive plan of care under subsection (h).

(f) The nursing facility shall conduct or coordinate each assessment with the participation of appropriate health professionals.

(g) A registered professional nurse shall conduct or coordinate each comprehensive assessment and shall sign and certify that the assessment has been completed.

(h) Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment.

(2) The comprehensive care plan shall be:

(A) Developed within seven days after completion of the comprehensive assessment; and

(B) prepared by an interdisciplinary team including the attending physician, a registered

nurse with responsibility for the care of the resident, and other appropriate staff in other disciplines as determined by the resident's needs, and with the participation of the resident, the resident's legal representative, and the resident's family to the extent practicable.

(i) The services provided or arranged by the facility shall:

(1) Meet professional standards of quality; and

(2) be provided by qualified persons in accordance with each resident's written plan of care.

(j) Discharge summary. When the facility anticipates discharge of a resident, a discharge summary shall be developed which includes the following:

(1) A recapitulation of the resident's stay;

(2) a final summary of the resident's status which includes the items found in the comprehensive assessment, K.A.R. 28-39-151 (a). This summary shall be available for release at the time of discharge to authorized persons and agencies, with the consent of the resident or the resident's legal representative; and

(3) a post-discharge plan to assist the resident in the adjustment to a new environment. The resident, and when appropriate, the resident's family, shall participate in the development of the plan. (Authorized by and implementing K.S.A. 39-932; effective Nov. 1, 1993; amended Feb. 21, 1997.)